

## Initial History Questionnaire

Form Completed By: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Age: \_\_\_\_\_  M  F  Other

### Birth History

Don't know birth history

Birth Weight: \_\_\_\_\_ Term  Preterm  \_\_\_\_\_ Weeks

Delivery Method: Vaginal  Cesarean  If cesarean, why? \_\_\_\_\_

Prenatal/Neonatal Complications? Yes  No  If yes, please explain:

### General

DK = Don't Know

Does your child have any current serious illness or chronic medical conditions?

Yes  No  DK  If yes, please explain:

Has your child had any surgeries or hospitalizations?

Yes  No  DK  If yes, please explain:

If your child allergic to any medications?

Yes  No  DK  Hasn't taken any prescription medications

### Biological Family History

DK = Don't Know

Please indicate if any of the child's biological family members have the following:

Childhood Hearing Loss	Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/>	Kidney Disease	Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/>
Asthma	Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/>	Diabetes Before Age 25	Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/>
Heart Disease Before Age 55	Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/>	Bedwetting After Age 10	Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/>
High Cholesterol/Takes Medication	Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/>	Epilepsy/Seizures	Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/>
Bleeding Disorders	Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/>	Developmental Disability	Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/>
Mental illness/Depression	Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/>	Immunodeficiency	Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/>
ADHD	Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/>	Eczema/Allergies	Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/>

Please provide explanation for all items with "yes" response. Include any additional history not indicated above.

## Social History

Please indicate child's living situation if not with both biological parents:

Lives with adoptive parents       Joint Custody       Single Custody

Lives with foster family       Other  \_\_\_\_\_

Is there tobacco use in the home?

Yes       No

## Patient Past Medical History

Does your child have or had any additional medical problems not discussed under "General" section

Yes       No       If yes, please explain:



**Patient's Name:**

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Sex: M / F

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone #: \_\_\_\_\_ Cell#: \_\_\_\_\_  
Select as Primary  Select as Primary

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

**How would you like to receive communications from us:** Text Email Phone call

**Ethnicity:** Hispanic/Non-Hispanic **Race:** African American / Asian / Caucasian / Native American

Pacific Islander / Other: \_\_\_\_\_ / Refuse **Preferred Language:** \_\_\_\_\_

**Primary Insurance Plan:** \_\_\_\_\_ Policy # \_\_\_\_\_ Subscriber: \_\_\_\_\_

**Secondary Insurance Plan:** \_\_\_\_\_ Policy # \_\_\_\_\_ Subscriber: \_\_\_\_\_

**Parent/Guardian's Name:**

Last: \_\_\_\_\_ First: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

**Parent/Guardian's Name:**

Last: \_\_\_\_\_ First: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

**Emergency Contact/Relationship:** \_\_\_\_\_ Phone #: \_\_\_\_\_

**I HAVE READ AND UNDERSTAND THE FOLLOWING FINANCIAL STIPULATIONS:**

I authorize Wee Care Pediatrics to provide medical care for my child as necessary. I understand that I am financially responsible for any amount not covered by my insurance plan and co-pay's or deductibles are due at the time of service. I authorize Wee Care Pediatrics to release my insurance information for the purpose of administrating claims for benefit reimbursement. I understand it is my responsibility to update changes on my health insurance or contact information, failure to do so may result in my financial responsibility and or collections and fees for unpaid balances due. All information provided will be protected in accordance with HIPAA guidelines.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Parent or Legal Guardian



## Payment Policy and Procedures

Thank you for choosing Wee Care Pediatrics for your child's medical care. The following is an explanation of our payment procedures and office policies. Please read carefully, print and sign below.

1. Payment is due at the time of service. We do not bill for deductibles or co-pays. We accept cash, Visa, MasterCard, Discover and American Express. **We do not accept personal checks.** Patients utilizing our cash pay program must pay before each visit.
2. The parent or guardian who brings the child for their visit is responsible for payment at the time of service. We do not intervene between divorced/separated parents or in the matter of custody issues, reimbursement will need to be between parents or guardians.
3. Appointments must be cancelled within 4 hours of the scheduled time to avoid a \$45.00 No Show Fee.
4. Account balances must be paid prior to any future visits. If a balance is due, a payment must be collected, or payment arrangements made before being seen. Emergent cases will be considered.
5. Account balances that exceed 90 days past due are sent to Vegas Valley Collection Service. You will be responsible for all collection and legal fees that accrue by the agency. Payment must be made before any future appointments. By signing below, you are agreeing that Vegas Valley may contact you via phone or personal email if your account is sent to collections.
6. We will gladly bill your primary and or secondary insurance for you. It is your responsibility to keep your **Coordination Of Benefits** current with your insurance providers. Failure to do so may result in lack of payment from your carriers. We are not responsible for non-payment from your insurance plan due to missing COB's and any balances will become subscriber responsibility due in full. **\*Failure to disclose a Commercial Insurance as Primary when you have Nevada Medicaid constitutes Medicaid Fraud and Abuse.** Medicaid states we must bill your Primary Insurance first before billing Medicaid.
7. In order to bill your insurance company, we must have an up-to-date insurance card. If we are unable to verify your insurance coverage at time of service, you will be considered a cash pay patient.
8. Most importantly, Wee Care Pediatrics wants the best care possible for your child and we understand you may have certain financial difficulties. Please feel free to discuss any financial matters with our billing department.

**I have read the above policy and agree to abide by the terms of this agreement.**

Signature: \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Legal Guardian Print Name Signature

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### **Acknowledgement of Notice of Privacy Practices**

The Notice of Privacy Practice describes how this office will use and disclose your protected health information, your privacy rights regarding your protected health information, this office's obligations concerning the use and disclosure of your protected health information. I acknowledge that the Notice of Privacy Practices will be furnished to me for my review at any time upon my request. I further acknowledge that the Notice of Privacy Practices may be located at [www.weecarelv.com](http://www.weecarelv.com) under patient forms as well as posted in office for review. Please advise our front desk if you would like a copy for immediate review.

Signature: \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Legal Guardian Printed Name

### **No Show Policy**

A **\$45.00 No Show fee** will be billed to those who miss their scheduled appointments. You are responsible for canceling or rescheduling your appointment if you cannot attend. We gladly send a courtesy reminder by voice, text, or email prior to your appointment day and time. Upon the 4<sup>th</sup> No show, you may be dismissed from the practice. I understand that it is my responsibility to arrive on time for my appointment and that I may not be seen if I am late.

### **3 Strike Policy**

Wee Care Pediatrics tries to provide a welcoming and friendly experience and does not tolerate the mistreatment of staff or property. Instances where a strike may be given: Abusive behavior towards staff, destruction of any Wee Care property such as furniture or exam rooms, will receive a strike. Extreme instances such as theft of Wee Care property, supplies or equipment will result in immediate dismissal. We simply ask that patience and kindness be observed while at Wee Care Pediatrics.

Signature: \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Legal Guardian Printed Name

